

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043341

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

93

Primary Registration District No.

4153

Registrar's No.

63-77

STATE FILE NUMBER

FILED NOV 19 1963

1. PLACE OF DEATH

a. COUNTY

Dade

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

Lockwood Mo.

Length of stay in 1b

yrs

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Memorial Hospital

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo

b. COUNTY

Dade

c. CITY
OR
TOWN

Lockwood Mo

Inside Limits
Yes ☐ No ☐

d. STREET
ADDRESS

209 w 6th St

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

First

Middle

Last

Lowell

Encil

Garrison

4. DATE OF DEATH

Month

Day

Year

Nov

11

1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married

Never Married ☐

Widowed ☐

Divorced ☐

8. DATE OF BIRTH

Jan 4 1906

9. AGE (last birthday)

57

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

City Marshall

Law enforcement

Fort Branch Ind

usa

13a. FATHER'S NAME

Thomas N Garrison

13b. MOTHER'S MAIDEN NAME

Nellie Douglas

14. NAME OF HUSBAND OR WIFE

Geraldine Garrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Geraldine Garrison Lockwood Mo.

18. CAUSE OF DEATH (Enter only one cause per line - for part I, part II, and part III)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Carcinoma

INTERVAL BETWEEN ONSET AND DEATH

2 mo

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

primary - Reticulum cell sarcoma

1 yr

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Nov 4, 1963 to 11-11-63 and last saw him alive on 11-11-63
Death occurred at 5:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

Nov 14 1963

ADDRESS

Lockwood

25. DATE RECD BY LOCAL REG.

11/14/1963

26. REGISTRAR'S SIGNATURE

J.C. Canada

Allison Funeral Home Greenfield M.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR
TYPEWRITER RIBBON
Bauer, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

1 0291

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NOV 27 1963

DEC 13 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.